

Application for License to
Operate a Long-term Care Facility

For Office Use Only
Received 1.9.12
Amount \$525.-

emailed Validation
letter
1/10/12

I. IDENTIFICATION

Name Williamson ARH Nursing Facility
Address 260 Hospital Drive
City/County/Zip South Williamson, KY 41503
Telephone number 606-237-1725
Administrator Sonya Wasserman, RN BSN
Date facility operation began at current address 06-28-1963
Date facility began operation under current owner 06-28-1963

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	<u>35</u>	
Nursing Home		
Nursing Facility	<u>35</u>	<u>35</u>
Intermediate Care		
ICF/MR		
Personal Care		

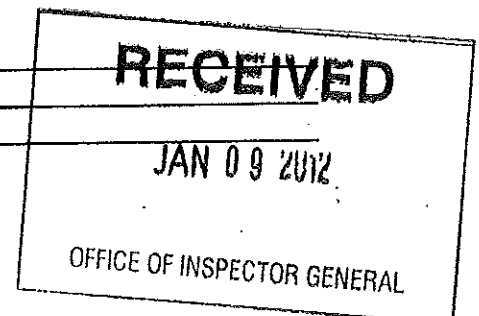
II. CONTROL (check one in each column)

	Profit	Individual
State		
County	X Nonprofit	Partnership
City		X Corporation
X Private		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Appalachian Regional Healthcare, Inc.
222 Executive Drive, Suite 400
Lexington, KY 40533



(OVER)

pb

If facility owned or leased by a corporation, complete the following:

Name of corporation Appalachian Regional Healthcare, Inc.
Address of corporation 222 Executive Drive, Suite 400, Lexington, KY 40533
President or Chairman Jerry Haynes
Vice President _____
Secretary _____
Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent

Management Company

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Jim A. Hildreth
Signature of authorized representative

CCED Williams 1/6/2012
Title Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)